Palominas School District

Student Health Information

Child's Name_____ Sex_____ Grade_____ Birthdate_____
Home Address_____ Phone Numbers_____
Mailing Address_____ZIP _____
Father's Name_____ Employer _____
Occupation _____ Work Number_____
Mother's Name _____ Employer _____
Occupation_____ Work Number _____

Name of a responsible adult we may contact in case parents/guardian cannot be reached in emergency.

_____

Name Address Phone # Relationship

Local
Doctor_____Hospital_____

Is your child restricted from participating in an active physical education program?

No ☐ Yes ☐ Reason: _____

Please update changes in your child's medical history made during the past year:

Medical	Date	Describe	Medications
Allergy			
Anemia			
Asthma			
Chicken Pox			
Convulsion			
Diabetes			
Eye, Ear, Nose Disease			
Heart Condition			
Hernia			
Mental Health Concerns			
Orthopedic Conditions			
Rheumatic Fever			
Strep Inf. or Scarlet Fever			
Tonsillitis			
Tuberculosis or Contact			
Valley Fever			
Operations			
Serious Injury, Accident			
Other			

Is your child allergic to anything such as food, plants, or insects?

Yes ☐ **What:**_____ **No** ☐

Does your child have the following:

- ☐ Frequent Colds
- ☐ Frequent Sore Throats
- ☐ Frequent Ear Infections
- ☐ Frequent Headaches
- ☐ Frequent Stomachaches
- ☐ Hearing Problems
- ☐ Vision Problems/Wears Glasses
- ☐ ADD/ADHD

List any medication your child is currently taking and why: _____

_____

_____

_____

Please list any other information that would help the nurse in providing good health care for your child.

_____

_____

_____

_____ _____

Parent/Guardian's signature Date

Form updated 3/23/18 WL